REMARKS

Claims 34-53 stand rejected. Claims 34-37, 42, 43, 45-47, 49, 50 and 52 are now amended. Claim 44 is cancelled. Claim 54 is newly added. Applicants respectfully request reconsideration in view of the foregoing amendments. No new matter has been added.

Summary of Claim Amendments

Support for amended independent claims 34, 35 and 37 can be found at least at the published U.S. Publication No. 2002/0133503 application at FIG. 2A and paragraphs [0089], [0091], [0094], [0104] and [0114]. With respect to independent claims 34, 35 and 37, the medical practice management server alerts a medical care provider to correct an error with a claim before submission of an incorrect claim to a payor server. This enables medical care providers to generate claims with no errors for the mutual benefit of the medical care provider and the payor. For example, if a referral/preauthorization is required for a claim but does not exist, the workflow processing engine does not submit the claim and waits for further updates/edits. See [0076]. In one embodiment, the workflow processing engine assigns a hold status to the incorrect claim to denote that the claim cannot currently be transmitted to the payor server. See [0089]. The medical care provider can correct claims that have errors via the claim edit screen and/or claim review screen. In one embodiment, the rules engine scrubs the claim again following the edits by the medical care provider and the workflow processing engine assigns a DROP status (e.g., identifies a claim that is ready to be billed) to the claim if no errors are found. See [0094].

Support for amended dependent claim 43 can be found at least at paragraphs [0041], [0059] and [0095]. Support for new claim 54 can be found at least at paragraphs [0089], [0094] and [0103-0104]. Claims 36, 42, 45-47, 49, 50 and 52 have been amended to provide proper antecedent basis.

Rejections Under 35 U.S.C. §101

Claims 34-53 are rejected under 35 U.S.C. §101 as failing the machine or transformation test. Claims 34, 35 and 37 have been amended to recite the machine or apparatus to which it is tied.

Rejections Under 35 U.S.C. §112

Claim 43 is rejected under 35 U.S.C. §112, first paragraph. Applicants have amended claim 43 to recite "receiving approval from a medical care provider using the medical practice client for the allocated payments among the charge line items; and posting the allocated payments to an account of the medical care provider."

Claim 44 is rejected under 35 U.S.C. §112, second paragraph. Applicants have cancelled claim 44.

Rejections Under 35 U.S.C. §103(a)

Claims 34-35, 37-45 and 48-52 are rejected under 35 U.S.C. §103(a), as being upatentable over U.S. Patent No. 7,016,856 by Wiggins ("Wiggins") in view of U.S. Patent No. 6,208,973 by Boyer et al. ("Boyer"). Claims 36 and 53 are rejected under 35 U.S.C. §103(a), as being upatentable over Wiggins in view of Boyer and in further view of U.S. Patent Application Publication No. 2002/0120473 to Wiggins ("Wiggins '473"). Claims 46-47 are rejected under 35 U.S.C. §103(a), as being upatentable over Wiggins in view of Boyer, as applied to claim 34 above, and in further view of U.S. Patent Application Publication No. 2002/0046165 to Kitchen et al. ("Kitchen").

For a rejection under 35 U.S.C. §103 (a) to be proper, the references, either alone or in combination, must teach or suggest all of the claim limitations. Applicants respectfully submit that none of the applied references, either alone or in combination, teach or suggest every element of the claimed invention.

Specifically, Wiggins and Boyer fail to teach or suggest at least the following limitations of amended independent claim 34:

- automatically interacting with the completed claim submission via the computer to correct an error in the completed claim submission, wherein the error is resolved by the medical practice client before processing the completed claim submission, by applying one or more rules from a class of

rules associated with the payor server, wherein the one or more rules comprises a new rule, an updated rule, or both received from the payor server

Wiggins discloses processing claims relating to transactions covered by a capitation agreement. See Wiggins, col. 3, ll. 9-13; col. 4, ll. 61 - col. 5, ll. 3; and col. 16, ll. 64 – col. 17, ll. 2. A capitation system is a system which charges a set fee per patient to provide access to health care goods or services. See Wiggins, col. 8, ll. 1-3. The capitation system verifies if the line items on the encounter form are all within the capitation agreement. See Wiggins, col. 17, ll. 12-14. If the capitation encounters contain both capitated and non-capitated line items within the same encounter form, a claims filing error report will be created and forwarded back to the provider for resubmission. See Wiggins, col. 17, ll. 23-27. As such, Wiggins merely tracks capitation payments. For example, Wiggins discloses that if the capitation payment is not within EA tolerances, ARMS reconciliation process will create a workload for the reconciliation specialist who will interact with the payor and capitation system to determine the source of errors in the payment. See Wiggins, col. 18, ll. 33-37.

Wiggins does not disclose automatically interacting with the completed claim submission to correct an error in the completed claim submission. Rather, Wiggins discloses that when claims are received via office automated systems, basic EMC edits will be performed and a filing error record will be formatted which can be read by a provider's office automation systems for correction and refiling. *See* Wiggins col. 17, ll. 3-7; see also col. 17, ll. 23-26, emphasis added. Specifically, Wiggins discloses the refilling process occurs "with any claim being processed in which the system detects an error which cannot be corrected by the system or system user personnel, or any error that affects the billed amount." Wiggins col. 17, ll. 31-35. In other words, Wiggins does not take action to resolve an error prior to processing the claim, but instead discloses post-processing error correction and resubmission of the claim. Thus, rather than requiring refiling of a claim requiring correction of an error by a provider's office as disclosed in Wiggins, the present application automatically interacts with the completed claim submission to correct an error in the completed claim submission when the error must be resolved by the medical practice client.

Wiggins discloses the system may provide linkage between coded data (diagnostic codes, drug codes, error codes, surgical codes, etc.) and a rule. Wiggins, col. 18, ll. 53-62. While Wiggins discloses using rules and codes, Wiggins fails to teach or suggest that the one or more rules comprises a new rule, an updated rule, or both received from the payor server. In particular, Wiggins fails to teach or suggest the rules are received from the payor server.

Boyer fails to cure the deficiencies of Wiggins. Boyer discloses that a healthcare provider may have software that includes claim data entry and submission through a claims processor. Boyer, col. 1, ll. 49-55; col. 14, ll. 22-44. While Boyer discloses providing live data validation and screening via an interface at the Internet bank's web site, Boyer fails to disclose automatically interacting with the completed claim submission using a computer to correct an error in the completed claim submission, wherein the error is resolved by the medical practice client before processing the completed claim submission. While Boyer discloses that the claim is then validated and the results of the adjudication are analyzed to infer any new rules for updating of the adjudication rules, Boyer fails to disclose automatically interacting with the completed claim submission by applying one or more rules from a class of rules associated with a payor server. Instead, Boyer discloses applying rules for claim adjudication rather than rules for correcting an error in the completed claim submission. Boyer, col. 15, ll. 1-6; col. 16, ll. 4-6. Additionally, amended independent claim 34 recites the one or more rules comprises a new rule, an updated rule, or both received from a payor server. Boyer fails to disclose this limitation, and discloses, at best, that the rules are updated based on the results of the adjudication. Boyer, col. 16, ll. 3-6.

Additionally, Wiggins and Boyer fail to teach or suggest at least:

- automatically associating a first claim status with the completed claim submission indicative of the claim not satisfying one of the one or more rules

Wiggins discloses assigning identifiers to document or elements of information for storage. See col. 6, ll. 63-col. 7, ll. 27. While Wiggins discloses that the status of the various contractual documents and relationships can be logged in the activity management system, Wiggins discloses that a contract specialist logs the status, not

"automatically associating a first claim status with the completed claim submission." *See* Wiggins, col. 8, ll. 9-14; col. 9, ll. 55-67; col. 11, ll. 8-15; and col. 12, ll. 1-5; 35-38. As such, logging is done by a patient specialist rather than being assigned automatically. At best, Wiggins discloses creating a deleted claims file that updates a clip file, which is an information storage file used to retain information during claims processing. Wiggins, col. 16, ll. 64 - col. 17, ll. 62.

Boyer fails to cure the deficiencies of Wiggins. Boyer merely describes that the claim submission process is corrected by providing live data validation and screening via an Interactive claim Submission (ICS) interface at the Internet bank's web site. Boyer, Col. 14, ll. 30-33. Boyer fails to teach or suggest automatically associating a first claim status with the completed claim submission indicative of the claim not satisfying one of the one or more rules as described in amended independent claim 34.

Wiggins and Boyer also fail to teach or suggest at least:

- transmitting data indicative of a claim edit screen to the medical practice client, the claim edit screen comprising a claim edit section for editing the completed claim submission and a claim error explanation portion to explain one or more errors in the completed claim submission to the medical practice client;

As stated in the Office action, "Wiggins fails to explicitly disclose transmitting data indicative of a claim edit screen to the medical practice client, the claim edit screen comprising a claim edit section for editing the completed claim submission." Office action, p. 7.

Boyer fails to cure the deficiencies of Wiggins. Boyer is concerned with claim adjudication rather than scrubbing a claim based on rules. Boyer, col. 15, ll. 1-6. Boyer discloses the system enables the healthcare provider 12 to enter a claim and interactively adjudicate that claim on-line using the Internet. See col. 14, ll. 4-67. While Boyer discloses the claim submission process is corrected by providing live data validation and screening via an Interactive claim Submission (ICS) interface at the Internet bank's web site, Boyer fails to disclose or even suggest the specific elements disclosed above, namely a claim edit screen comprising a claim edit section for editing the completed claim submission and a claim error explanation portion to explain one or more errors in the

completed claim submission to the medical practice client. *See* the present application at FIGS. 7D-7E and paragraph [0094] and [0104].

Finally, Wiggins and Boyer fail to teach or suggest at least:

- receiving data indicative of an updated completed claim submission from the medical practice client;
- correcting the completed claim submission based on the updated completed claim submission; and
- automatically associating a second claim status with the completed claim submission indicative of the completed claim submission satisfying all of the one or more rules.

As discussed above, if there are errors with a claim, Wiggins requires a re-submission of the claim by the client rather than automatically correcting the completed claim submission based on the updated completed claim submission. The only edits done in Wiggins to a claim submission without requiring a re-submission are by the system user's staff, not the medical practice client. Additionally, Wiggins does not disclose automatically associating a claim status with a claim submission. As discussed above, Boyer fails to cure these deficiencies of Wiggins.

Neither Wiggins '473 nor Kitchen cure the deficiencies of Wiggins and Boyer. Wiggins '473 discloses a method and system for enabling a service provider to file insurance claims via the internet directly with the payer rather than through a clearinghouse. Wiggins '473, Abstract. Kitchen discloses a method of electronically presenting billing information, includes receiving billing information associated with a plurality of different billers, different portions of which represent bills for different payors. Kitchen, abstract.

Accordingly, for the above reasons, Applicants respectfully submit that none of the applied art render amended independent claim 34 obvious under 35 U.S.C. § 103(a). Amended independent claims 35 and 37 include similar limitations to independent claim 34 and are allowable for at least the same reasons.

Further, with respect to claim 35, none of the applied references teach or suggest automatically associating a third claim status with the completed claim submission

indicative of the information being transmitted to the payor server as discussed above with reference to claim 34.

Further, with respect to claim 37, none of the applied references teach or suggest receiving data indicative of a new rule, an updated rule, or both from the payor server; and automatically updating the class of rules associated with the payor server to reflect the received data as described above with respect to claim 34.

Dependent claims 36, 38-43 and 45-54 depend, directly or indirectly, from allowable base claims, and are allowable for at least the same reasons.

CONCLUSION

Applicants request that the Examiner reconsider the application and claims in light of the foregoing amendment and response, and respectfully submit that the claims are in condition for allowance. If the Examiner believes that a telephone conversation with Applicants agent would expedite allowance of this application, the Examiner is cordially invited to call the undersigned agent.

Respectfully submitted,

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